CHC
Community Hospital Corporation

January 29, 2018

Marlene H. Dortch, Secretary
Federal Communications Commission
445 12th Street, S.W.
Washington, DC 20554

RE: Promoting Telehealth in Rural America – WC Docket No. 17-310

Madam Secretary,

Community Hospital Corporation (CHC) would like to take the opportunity to comment on the Notice of Proposed Rulemaking and Order in the Rural Health Care (RHC) program (NPRM and Order).

CHC applauds the Commission's recognition that the Rural Health Care (RHC) Program is in dire need of modifications. CHC agrees with some recommendations and disagrees with others, but the NPRM and Order have provided a pathway to align the goals of the RCH program among applicants and USAC to improve efficiency, increase program reach, reduce administrative burdens, and curb waste, fraud and abuse.

The cap on RHC funding has remained static since the program's inception, at which time support was limited to T1 or less. As technology advanced and the idea of telemedicine came to fruition, the Commission modified the rules to allow for the advancements, but added no financial adjustments to address the impact of those technological advances. CHC supports the suggestion that the cap be adjusted annually by inflation, from inception. CHC also supports the suggestion to roll over funds from previous years, to be distributed without prioritization. CHC also advocates the idea that USAC administrative costs should not reduce the funds available to HCPs.

Currently, multi-year commitments are deducted from the funding year in which they were requested/approved. CHC suggests that multi-year commitments be allocated to the funding year in which the funds will be used, without impact to the following funding year's cap for multi-year commitments and upfront costs.

CHC does not support any suggestions that would provide prioritization of funding to any facility, entity type, region, tribal affiliation, rurality, or program. The definition of rural area in §54.600(b) of the Commission's rules meet the needs of the RHC Program and CHC does not support any update or modification to the definition. While understanding that rurality is the driving force between rural market rates, CHC does not agree to a tiered or prioritization based approach. Instead, we affirm that the current pro rata mechanism promotes fair funding practices for applicants.

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CHC does not support a requirement that mandates a healthcare-service relationship between an HCF consortium's non-rural and rural healthcare providers that receive Program support, but does support reduction of the consortia grace period to one year.

To promote efficiency and reduce waste the Commission has suggested benchmarks for identification and enhanced scrutiny of outlier funding requests. CHC supports enhanced controls, but establishing benchmarks based upon a previous year's data will not be an accurate indicator. For example, in FY2016 the urban rate posted by USAC for a "Voice Grade (Single Termination)" in Louisiana was $4.55. In FY2017, USAC posted an urban rate of $45.00 for that same service - an increase of almost 900%. In many regions, rural Healthcare providers have a single service provider available which leaves them with no bargaining power. At an alternate angle, CHC has observed service provider practices which it believes to be predatory and undermines the competitive bidding process. CHC believes service providers within the program need to be held at a higher level of standards and bear the burden of their compliance verification. Intentional violations should be met with swift and direct consequences to the service provider, not the unknowing Healthcare provider.

With the intention of reducing waste, improving efficiency, streamlining process, and enforcing compliance; CHC supports an alternative solution. We implore the Commission to consider whether modification of the current support structure (rural rate, less urban rate) to a percentage per service, per state approach could be a viable alternative calculation method. By using data already vetted by USAC, calculation can based upon the average of the three preceding funding years. This method of support would eliminate funding uncertainty among applicants and while utilizing readily available data. It also reduces or eliminates additional administrative burdens on applicants to provide rural rate calculation compliance, potential manipulation of rural and urban rates, potential manipulation of the competitive bidding process, and reduces the administrative burden on USAC. This method should also result in applicants selecting service types and bandwidths based upon need. The Commission should feel confident that utilizing previously submitted data eliminates the possibility of data manipulation.

- Example a - During FY14-FY16 if 247 Healthcare providers in Louisiana received an average discount of 90% for business telephone lines. FY2017, all eligible funding requests for business telephone lines in Louisiana are funded at 90%.

Fund Year	Criteria	Discount
2017	FY14-FY16	90%
2018	FY15-FY17	92%
2019	FY16-FY18	94%
2020	FY17-FY19	93%

Fund Year	Criteria	Discount
2021	FY18-FY20	93%
2022	FY19-FY21	93%
2023	FY20-FY22	93%
2024	FY21-FY23	93%

- Example b - During FY14-FY16 if 122 Healthcare providers in Louisiana received an average discount of 93% for 100M Ethernet service. FY2017, all eligible funding requests for 100M Ethernet services in Louisiana are funded at 93%.

Fund Year	Criteria	Discount
2017	FY14-FY16	93%
2018	FY15-FY17	97%
2019	FY16-FY18	97%
2020	FY17-FY19	96%

Fund Year	Criteria	Discount
2021	FY18-FY20	96%
2022	FY19-FY21	96%
2023	FY20-FY22	96%
2024	FY21-FY23	96%

The alternative support calculation method should also reduce funding approval timelines. If funding requests exceed a cap for a given funding year, the pro rata factor already utilized by USAC will be fair and applied to all eligible commitments. The pro rata factor should not be used for the purpose of calculating discount averages.

CHC does not agree that the Commission should define "cost-effectiveness" as the lowest-price service that meets the minimum requirements. This language opens the door for service or bandwidth caps and will hamper forward momentum in telemedicine for rural Healthcare providers, in a rapidly evolving technology landscape.

While improving oversight of the RHC program, the Commission should promote invoice and disbursement visibility for applicants in the Telecom program. Transparency into this portion of the program will help to ensure that credits are being applied to applicant accounts accurately and in a timely manner. The Commission should put rules in place to define when credit must be applied to the applicant's account. Currently, USAC states "*Once the service provider has received and reviewed the HCP Support Schedule (HSS), the service provider <u>should</u> credit the applicant.*" CHC encourages the Commission to refine this language so that a service provider is required to apply the credit to an applicant's account within 5 business days of a) submission of the invoice, or b) disbursement of funds.

CHC supports ways to streamline and improve efficiency and agrees with the proposal to use four forms, eliminating the need to switch between programs. CHC also supports unified data collection on RHC support impact, so long as the data collection and review process does not cause delays in processing funding requests.

Rural Healthcare providers are experiencing extreme financial impacts to their operational budgets due to the unforeseen extended delay in the processing of FY 2017 applications. In funding years 2013-2016, our facilities saw funding applications process in an average of 62 days – which was exacerbated by the implementation of the second filing window in 2016. If the FY 2016 window is excluded from the calculation, the average processing time was 43 days. In

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FY 2017, some applicants have waited more than 10 months with little to no update regarding the status of their applications. Since service providers require payment, healthcare providers are forced to stretch already limited budgets. FY 2017 is at a halt and FY 2018 filing has already begun with an aspect of uncertainty and questions of program stability; impacted facilities will not be able to determine need vs. budget.

In conclusion, CHC supports the initiative to increase program reach, promote efficiency, reduce waste and align the two RHC programs' forms in order to ease administrative burdens while streamlining overall processes. We respectfully, and firmly, disagree with any measures that will prioritize funding among applicants, increase administrative burdens or hamper strategic growth and expanded telehealth reach.

Respectfully submitted,

/s/

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